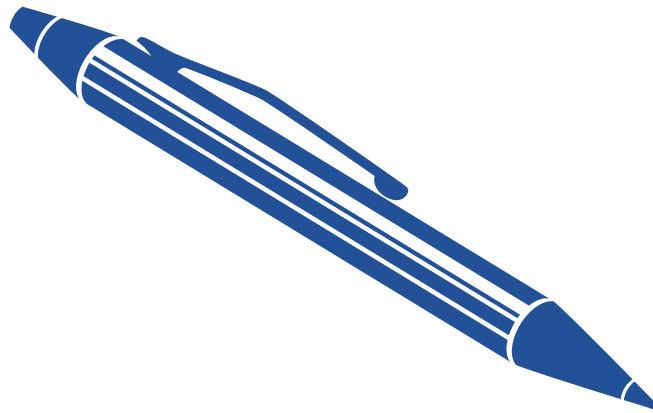


Application for

The CalPERS Partnership Comprehensive Plan



Questions?


If you have any questions about the CalPERS Long-Term Care Partnership Comprehensive Plan, or if you would like assistance in completing your application, please call toll free at **1-800-908-9119** Monday through Friday from 7:00 a.m. to 7:00 p.m. Pacific time.



Long-Term Care Program

Instructions

How to fill out your application for the CalPERS Partnership Comprehensive Plan

This application is to be used by all California public employees or retirees or annuitants (monthly allowance recipients) of CalPERS, CalSTRS or other California public retirement systems; or their spouses or parents or parents-in-law. Please complete all sections and **sign and date** each line where the  symbol appears.

EACH PERSON APPLYING FOR COVERAGE MUST COMPLETE A SEPARATE APPLICATION.

Section A. Eligible Member Information

If your application kit has a mailing label on the outer envelope, place it in Section A of the application. Print any corrections directly on the label. If you do not have a label, check the appropriate box in Section A and complete the information requested.

Section B. Applicant Information

Be sure to complete all information and **sign and date** where indicated.

Section C. Medical Questions

Provide all requested medical information, including your height and weight. If you need more room for your answers to any question, please use a separate sheet of paper. We expect that you will answer “yes” to some of the questions. That’s perfectly normal and by itself may not disqualify you from coverage.

In addition to the application, we may obtain your medical records from your doctor. If you are 74 years old or younger, a nurse may call you to conduct a telephone interview. If you are age 75 or older, a nurse may arrange a convenient time to speak with you in person.

Section D. Attending Physician Information

Be sure to complete all attending physician information.

Section E. Authorization for Release of Information

Provide required **signature and date** to authorize the release of medical information.

Section F. Replacement Information (required by law)

Indicate whether you have existing long-term care coverage and whether you intend to replace it with this coverage (complete all four questions).

Section G. Authorized Designee

Complete this section.

Section H. Plan Options

Indicate your plan option and amount of coverage. **Sign and date** in the space provided.

Section I. Payment Options

Indicate your deduction or payment method here and **sign and date** where applicable.

Make a copy of this application to retain for your records.

It’s a good idea to review the application again before sending to make certain all information is complete and that Sections B, E, H and I are **signed and dated**.

Mail your application in the postage-paid envelope provided. Do not send payment at this time; we will begin deductions or bill you should your application be approved.

We will inform you of the decision we make concerning your application approximately four to six weeks after we receive it. Your coverage will become effective to coincide with your payment option.

Remember, the sooner we receive your application, the sooner your coverage may begin. Also remember, the cost for your coverage is based on your age when we receive your application. Your application will be returned if all places are not signed.

Please mail this application to: CalPERS Long-Term Care Program, P.O. Box 5708, Hopkins, MN 55343-5708.

Feel free to call Customer Service at **1-800-908-9119**, Monday through Friday, 7:00 a.m. to 7:00 p.m. Pacific time for help with your plan choices or in completing this form.

A. Eligible Member Information

PTNP-01

Eligible Member Information (active employee, retiree or annuitant) must be completed.

To expedite application processing, affix the mailing label here. If the label is being used on your spouse's application, write the **19-digit request number on the right.**

☐ Check here if you did not receive a label.

Name (First) (Middle Initial) (Last)

Social Security Number of Eligible Member Address

City State ZIP code

B. Applicant Information

☐ Check here if your spouse is also applying Spouse Social Security Number

I am applying as the (check the appropriate box):
☐ Active Employee ☐ Spouse of Retiree or Annuitant
☐ Spouse of Active Employee ☐ Parent of Active Employee, Retiree or Annuitant
☐ Retiree or Annuitant ☐ Parent-in-law of Active Employee, Retiree or Annuitant

Name (First) (Middle Initial) (Last)

Address

City State ZIP code

Date of Birth Social Security Number

Home Phone Number a.m. p.m. Best Time to be Reached Work Phone Number

E-mail Address

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Affiliation: ☐ CalPERS ☐ CalSTRS ☐ Other California Public Retirement System (please specify)

"I certify that I am eligible to apply for this coverage as defined in the application instructions."



Signature of Applicant

Date

1. Describe briefly **in your own handwriting** your current hobbies, volunteer work and regular exercise:

2. Are you currently employed and actively working? ☐ Yes ☐ No If "Yes," how many hours per week? _____

3. Are you receiving disability income, workers' compensation, SSI or any other state or federal disability benefits? ☐ Yes ☐ No If "Yes," please give details on nature and source of benefits.



CPAPPL0201

C. Medical Questions

TO BE COMPLETED BY THE APPLICANT

Please answer "Yes" or "No" by checking the box.

1. Do you **currently** require the "hands-on" assistance of, or supervision by, another person in performing any of the following activities: moving in/out of the bed or chair; controlling bowel/bladder; bathing; eating; dressing; or using the toilet? 1. ☐ Yes ☐ No
2. Are you **currently** receiving:
 - a. Nursing Home Care (in a nursing home or extended care unit of a hospital)? 2a. ☐ Yes ☐ No
 - b. Home Health Care (visiting nurse, therapist or health aide visits)? 2b. ☐ Yes ☐ No
 - c. Adult Day Care Services? 2c. ☐ Yes ☐ No
3. Have you **had**, do you **currently have**, or have you **been medically diagnosed** as having any of the following conditions:
 - a. Organic Brain Syndrome; Senility; Dementia; or Alzheimer's Disease? 3a. ☐ Yes ☐ No
 - b. Metastatic Cancer (cancer has spread from original site)? 3b. ☐ Yes ☐ No
 - c. Parkinson's Disease; Muscular Dystrophy; Multiple Sclerosis; Myasthenia Gravis; Amyotrophic Lateral Sclerosis (ALS); Huntington's Chorea; Multiple Strokes; Multiple Transient Ischemic Attacks (TIAs); Ataxia; or Hydrocephalus? 3c. ☐ Yes ☐ No
 - d. AIDS or AIDS Related Complex (ARC)? 3d. ☐ Yes ☐ No

In most cases, answering "Yes" to questions 1, 2 or 3 will disqualify you from acceptance into the program at this time. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. Although we would like to be able to offer coverage to all applicants, we need to exclude individuals who are currently eligible for or are receiving long-term care benefits. This screening allows us to keep premiums affordable to all participants. If your circumstances change, you may consider applying again during the next application period.

4. Do you **now** use or in the **past 12 months** have you used (check all that apply or **None**): ☐ **None**

Yes <input type="checkbox"/> Oxygen <input type="checkbox"/> Wheelchair	Yes <input type="checkbox"/> Quad cane <input type="checkbox"/> Kidney dialysis	Yes <input type="checkbox"/> Walker <input type="checkbox"/> Motorized scooter	Yes <input type="checkbox"/> Hospital bed in your home
--	--	---	--

Please describe checked item(s), and their use: _____

5. Please list each **prescription medication** you are **currently** taking and why. If you need more space to complete this section, please attach another sheet of paper. ☐ **Not currently taking medication**

<u>Medication</u>	<u>Dosage & Frequency (ex: 20mg/2 x a day)</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Please provide your **height** (ft. and in.) ft. inches and **weight** (lbs.)
7. Do you **currently** require any human assistance or supervision with any of the following daily activities? (check all that apply or **None**):

<input type="checkbox"/> Shopping	<input type="checkbox"/> Doing housework	<input type="checkbox"/> Managing finances	<input type="checkbox"/> Doing laundry
<input type="checkbox"/> Preparing meals	<input type="checkbox"/> Using transportation	<input type="checkbox"/> Taking medications	<input type="checkbox"/> None
8. During the **past three years** have you (check and describe below all that apply or **None of the above**):
 - ☐ Been medically advised to have surgery that has not been performed or consulted a specialist or health care professional other than your primary care physician? _____
 - ☐ Been admitted to or medically advised to enter a nursing home or an extended care unit of a hospital? _____
 - ☐ Received home care services (visiting nurse, nurse's aid, therapist or meals on wheels)? _____
 - ☐ Been a patient in a hospital, emergency room, outpatient surgery or other health care facility? _____
 - ☐ Used adult day care services or outpatient therapy (physical or occupational therapy or rehabilitation)? _____

☐ **None of the above**

Please describe: _____

C. Medical Questions *(continued)*

9. Within the **last three years** have you: consulted with a health professional, taken any medication, been medically diagnosed, or been confined to a convalescent facility, hospital or nursing home facility for any of the following conditions (*check all that apply below or **None of the above***):

- | | | |
|--|---|---|
| <input type="checkbox"/> 1. Alcohol or Drug Abuse | <input type="checkbox"/> 15. Diabetes | <input type="checkbox"/> 26. Kidney Failure/Kidney Disease |
| <input type="checkbox"/> 2. Anemia or Related Illness | <input type="checkbox"/> 16. Emphysema/Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> 27. Leukemia |
| <input type="checkbox"/> 3. Angina | <input type="checkbox"/> 17. Fainting Spells/Blacking Out | <input type="checkbox"/> 28. Macular Degeneration |
| <input type="checkbox"/> 4. Arthritis | <input type="checkbox"/> 18. Falls | <input type="checkbox"/> 29. Memory Loss |
| <input type="checkbox"/> 5. Asthma | <input type="checkbox"/> 19. Fractures | <input type="checkbox"/> 30. Osteoporosis |
| <input type="checkbox"/> 6. Back or Spine Injury | <input type="checkbox"/> 20. Heart Attack/Myocardial Infarction | <input type="checkbox"/> 31. Conditions Causing Crippling or Limited Motion |
| <input type="checkbox"/> 7. Blood Disorder (<i>Do not check if only blood disorder is HIV positive.</i>) | <input type="checkbox"/> 21. High Blood Pressure/Hypertension | <input type="checkbox"/> 32. Paralysis |
| <input type="checkbox"/> 8. Brain Disorder | <input type="checkbox"/> 22. Hodgkin's Disease/Lymphoma | <input type="checkbox"/> 33. Peripheral Vascular Disease |
| <input type="checkbox"/> 9. Cancer/Tumor | <input type="checkbox"/> 23. Immune System Disorder (<i>Do not check if only immune disorder is HIV Positive</i>) | <input type="checkbox"/> 34. Pressure Sores/Bed Sores/Skin Ulcers |
| <input type="checkbox"/> 10. Chronic Infection | <input type="checkbox"/> 24. Injury Due to Falls/Imbalance | <input type="checkbox"/> 35. Schizophrenia/Psychoses |
| <input type="checkbox"/> 11. Chronic Bronchitis | <input type="checkbox"/> 25. Joint Replacement | <input type="checkbox"/> 36. Shortness of Breath |
| <input type="checkbox"/> 12. Congestive Heart Failure (CHF) | | <input type="checkbox"/> 37. Stroke |
| <input type="checkbox"/> 13. Convulsions/Seizures/ Epilepsy | | <input type="checkbox"/> 38. Transient Ischemic Attack (TIA) |
| <input type="checkbox"/> 14. Depression/Manic Depressive Illness | | <input type="checkbox"/> 39. Tremor |
| | | <input type="checkbox"/> None of the above |

10. Please give details below to all boxes checked in **Question #9**. If you need more space to complete this section, attach another sheet of paper.

**Condition
Number**

**Physician's Name
Address and Phone Number**

Describe

11. Do you use any tobacco products? ☐ Yes ☐ No

D. Attending Physician Information

Please complete below for your Primary Care Doctor (physician with most of your medical records)

Do you have a primary care physician? ☐ Yes ☐ No

Have you seen this physician in the last two years? ☐ Yes ☐ No

Physician Name

Street Address

City

State

ZIP code

Phone Number

Name of Insurance Carrier

Kaiser or Medical Record # (if known)*

*For Kaiser patients: your application may be delayed if you do not include your medical record number.

E. Authorization for Release of Medical Information

THIS SECTION MUST BE COMPLETED

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, care provider, care manager or evaluator, insurance company or insurance support organization to give to the California Public Employees' Retirement System or its authorized representative any records or knowledge of me or my health needed to evaluate my application, including information regarding drug, alcohol or psychiatric treatment or results of an HIV antibody test. I agree that this authorization will be valid for 24 months from the date signed unless I revoke it in writing, and know that I or my authorized representative may have a photocopy of it. A photostat copy of this authorization is as valid as the original.

Applicant Name (please print) _____



Signature of Applicant

--	--	--	--	--	--	--	--	--	--

Date

F. Replacement Information (required by law)

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long-term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract providing long-term care services)? 1. ☐ Yes ☐ No

2. Are you covered by Medicaid (Medi-Cal)? (not a reference to Medicare) 2. ☐ Yes ☐ No

3. Did you have another long-term care, nursing home health care policy or certificate in force during the last 12 months? 3. ☐ Yes ☐ No

If so, which company? _____

If that policy lapsed, when did it lapse? _____

4. Do you intend to replace the above or any other long-term care, medical or health insurance with this coverage? 4. ☐ Yes ☐ No

If so, which company's coverage will you be replacing?

Company Name

Policy Number

Amount

Type of Coverage

Mailing Address

City

State

ZIP code

G. Authorized Designee

Please complete even if you elect not to have a designee.

I understand that I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this long-term care coverage for nonpayment of premium. I understand that this notice will not be given until 30 days after a premium is due and unpaid.

Please check one of the following:

☐ I elect **NOT** to name an authorized designee to receive this notice.

☐ I elect to name an authorized designee to receive this notice.

Complete the information below only if you elect to name an Authorized Designee.

Information about your designee:

First Name

Middle Initial

Last

Address

City

State

ZIP code

Phone Number

You may change the named designee at any time by notifying us in writing at the address on the instruction page.

H. Partnership Comprehensive Plan Options

*For benefits, plan option and rates, refer to the Plan at a Glance and Rate Sheet.
Please call 1-800-908-9119 if you need assistance with your plan choice.*

CHOOSE ONLY ONE OPTION. Put 'X' in box indicating coverage choice.

Option 100	
❑ \$36,500 of Coverage with inflation protection	❑ \$73,000 of Coverage with inflation protection

**O
R**

Option 130	
❑ \$47,450 of Coverage with inflation protection	❑ \$94,900 of Coverage with inflation protection

Please Read and Sign Here

I certify that I have reviewed all the information and notices contained in this application and that all information supplied on this form is true to the best of my knowledge. I also understand and agree that the coverage for which I am applying, if issued, shall be subject to these statements and will take effect on the effective date stated on the Schedule of Benefits. If statements in this application are fraudulent or materially untrue, sanctions which could include rescission of my coverage or benefit denial may be applied.

I understand that this is the first step to apply for a Partnership-approved long-term care program that qualifies for Medi-Cal Asset Protection under the California Partnership for Long-Term Care. To complete the application process, I am requesting the additional Partnership materials.

 _____
Signature of Applicant

Date

The benefits payable by the Plan qualify for Medi-Cal Asset Protection under the California Partnership for Long-Term Care. Eligibility for Medi-Cal is not automatic. If and when you need Medi-Cal, you must apply and meet the asset standards in effect at the time. Upon becoming a Medi-Cal beneficiary, you will be eligible for all medically necessary benefits that Medi-Cal provides at that time, but you may need to apply a portion of your income toward the cost of care. Medi-Cal services may be different than the services received under the private coverage.

I. Payment Options

Choose a payment or deduction option below. Please complete **both** Step 1 and Step 2. We ask you to select a second option in case we are unable to provide your preferred payment options as described below.

About Automatic Payroll or Pension Deduction Most, but not all, public employers and retirement systems offer Automatic Payroll Deduction or Automatic Pension Deduction. This is the easiest way to pay premiums. If you select either of these payment options in Step 1, please also indicate in Step 2 how you would prefer to make premium payments if automatic payroll or pension deduction is not available through your public employer or retirement system.

Step 1: Decide if you want Automatic Payroll or Pension Deduction if it is available to you. These options are NOT available to parents or parents-in-law of public employees, retirees or annuitants.

Please select one:

Automatic Payroll Deduction (Automatic Payroll Deduction for the **CalPERS Long-Term Care Program** is NOT available to part-time, seasonal or permanent intermittent employees. It also may not be available through all public employers)

☐ **Yes**, if Automatic Payroll Deduction is available through my public employer, I want to select this payment option.

"I certify that I am an active member (public employee actively at work). As such, I authorize my employer to deduct from my pay the required premium for my or my spouse's CalPERS Long-Term Care Plan."

Name (First) (Middle Initial) (Last) (if state employee, provide as it appears on your payroll check)

Name of Public Employer

Name of Department



Signature of Active Public Employee

Date

Social Security Number

OR

Automatic Pension Deduction (available to CalPERS and CalSTRS retirees or annuitants and their spouses. Please call 1-800-908-9119 for current pension deduction information on other California public retirement systems)

☐ **Yes**, if Automatic Pension Deduction is available to me, I want to select this payment option. (Please sign below)

I authorize the deduction of the CalPERS Long-Term Care Program premiums from my pension benefits received through the ☐ CalPERS ☐ CalSTRS or ☐ another California public retirement system (please specify)



Signature of Eligible Member

Date

☐ **No, I do not want either of these payment options.**

Step 2: Choose ONE of the following payment options. If you indicated 'No, I do not want either of these payment options' in Step 1, this will be your payment option. If you indicated 'Yes' to either payment option in Step 1, the option selected below will only be your payment option if Automatic Payroll or Pension Deduction is not available to you.

1. ☐ **Monthly Electronic Funds Transfer** (Also complete Section G.) I authorize CalPERS or its designated agent and the financial institution named below to initiate monthly withdrawals from my checking/savings account. This authority will remain in effect until I provide written notification to cancel to CalPERS or its designated agent and my financial institution.

I understand that if the necessary funds are not on deposit in my account on the day designated to execute the automatic deduction, I will be billed directly.

Please deduct my monthly premium from (check one):

☐ **Checking Account #**

(submit a VOIDED check only)

☐ **Savings Account #**

(submit a VOIDED deposit slip only)

Required to process this payment option.

Financial Institution Name

Telephone



Signature of Applicant

Date

2. ☐ **Bill me directly** (Select one billing frequency and complete Section G.) ☐ Annually ☐ Semiannually ☐ Quarterly